THE COMMONWEALTH OF MASSACHUSETTS
EXECUTIVE OFFICE FOR
ADMINISTRATION AND FINANCE
STATE HOUSE ▪ ROOM 373
BOSTON, MA 02133

DEVAL L. PATRICK
GOVERNOR

TIMOTHY P. MURRAY
LIEUTENANT GOVERNOR

JAY GONZALEZ
SECRETARY

TEL: (617) 727-2040
FAX: (617) 727-2779
www.mass.gov/anf

Medicaid Delivery Model Commission
Meeting 1 Minutes
July 17, 2012
1 Ashburton Place 11th Floor

1. Introductions
    a. Present: Senator Knapik, Senator Barros, Vicker DiGravio, Leanne, Secretary Gonzales, Glen Shor, Nancy, Ann, Aron, Kim, Tom Gen, MMS

2. Statutory Charge – Secretary Gonzales

3. Open Meeting and Conflict of Interest Laws Overview – David Sullivan, General Counsel EOAF

4. Program Overview – Dr. Harris

    a. Charge
    b. Context
    c. Overview of MassHealth
        i. Massachusetts has a long-standing history of managed care
    d. Types of members served by each program
        i. MCO Plan: MassHealth Standard, CommonHealth, Family Assistance, Basic and Essential programs
        ii. PCC Plan: individuals under age 65 with MassHealth standard, CommonHealth, Family Assistance, Basic and Essential benefits
        iii. Noted that there are 349,000 members in the full Behavioral Health program
        iv. Dr. Dimitri (Mass. Medical Society) question: did the change in the model change the costs?
    e. The PCC Plan
    f. MassHealth's MCO Plan
        i. Over time, there has been a national increase in managed care
    g. Recent Changes to the MCO Plan
        i. Nationally, 50% of people are in an MCO or PCC managed care plan
        ii. Medicaid is able to manage cost more effectively using the managed care plans

iii. Some concerns were highlighted centering around perceived differences in the populations on each plan

h. PCC Plan Care Coordination and Behavioral HealthProcurement
i. Patient-Centered Medical Home (PCMHI)
    i. This program is unique to Massachusetts
    ii. The pilot is coming to the end of its first year and is a $256,000 initiative
j. Asthma Bundled Payment Pilot
    i. There is enormous national interest in this
    ii. During phase 1, primary care sites will receive bundled payments to purchase AC or vacuum cleaner for children high-risk asthma patients
    iii. Nancy Turnbull (Harvard University): Asked whether any payments based on quality – there is no quality withhold currently but this will be looked into in the future
k. Current Payment Methods
l. Current Quality and Data Reporting for the PCC Plan
m. Current Quality and Data Reporting for the MCO Plan
n. Strengths of Each Plan
    i. While the cost of both plans is listed for reference, it is noted that cost is not comparable based on population differences by plan; a consultant is needed to find an accurate and representative comparison
    ii. Nancy Turnbull (Harvard): Asked whether access data included all providers – it does not, but for long-term care it is broken out by region
    iii. Massachusetts has a high rate of behavioral health needs, and MCO's have responded to that; one of the MCO's even has a behavioral health carve-in
    iv. Dr. Dimitri (MMS) noted that, in addition to having a robust care program in Massachusetts, we have the added benefit of having very robust providers
o. Senior Care Options (SCO)
    i. The difference is in long-term services
p. Duals Demonstration
    i. Massachusetts is the first state to develop the Integrated Care model for Dual Eligibles (because of our high rate of behavioral health needs)
    ii. Commissioner Boros (Division of Health Care Finance and Policy): asked about geographic regions – Medicare contracts are at the county level, open procurement
q. Senator Knapik: commented on the incredible evolution in publicly financed health care in the state. Asked whether MCO's have the capacity to absorb more of existing clients – they do and can be effective at cost containment, but some individuals are not eligible for the MCO program

r. Tim Gens (Mass. Hospital Association): Asked whether the difference in acuity is driving this – the differences in plans distinguish their risk profile; the MCO program tends to have a healthier population in general than the PCC program.

5. Goals and Guiding Principles (30 Minutes – Jay)

    a. Comments:
        i. Nancy Turnbull (Harvard): There is nothing about the members themselves and outcomes for them included. The 2 year time outline is a good starting point, though she hopes we would not restrict it to that at the end.
        ii. Leann Berge (Mass. Ass'n of Health Plans): Asked how the issue of price variation and fee schedule fits into the goals outlined – noted that this is an unspoken important factor. Commented that understanding the differences of the two models is the broader goal.
        iii. Dr. Dimitri (MMS): Noted the broad participation in the MassHeath program, and therefore it may be necessary to test the proposals of the Committee so as not to break portions of a functioning system. Also commented on the broad array of providers that will continue to participate.
        iv. Nancy Turnbull (Harvard): Noted that it will require sufficient administrative resources.
        v. Secretary Gonzalez (A&F): Commented that understanding of MassHealth resources is necessary in order to support different models.
        vi. Tim Gens (MHA): Commented on the sustainability of the delivery system. The Committee will need to look at what it is going to take to sustain changes throughout budget years. This will be a discussion related to Goal #2.

6. RFR Description and Comments (Jay)

    a. Request that everyone look at the RFR and provide feedback by the end of the week, as procurement is underway.